DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313 NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341				ETED
_				T +0541		(V.C.)
` '	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
· ·	OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
W0000						
This visit was recertification Dates of surve and 17, 2012 Facility number Provider number AIM number: Surveyor: Chrisurveyor III/Q The following state findings if 9. Quality Review	per: 15G313 100249150 ristine Colon, Medical	Wo	000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		15G313	B. WIN			08/17/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			MISSISSIPPI ST		
ARC OF	NORTHWEST IND	DIANA INC, THE			DN, IN 46341		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0104	483.410(a)(1) GOVERNING BOTHE governing be policy, budget, at the facility. Based on record governing body living at the grow	ody must exercise general and operating direction over direction o	W0		The Area Manager will have the carpet professionally cleaned within the next 30 days. Maintenance will repair all damaged areas/items within the next 30 days. To ensure future compliance, the Property Director, Maintenance Crew, A Manager, and staff will monito the condition of the carpet and home monthly and notify the appropriate persons of any changes. The Property Director Maintenance crew, Area Manager, and staff will monito the home quarterly thereafter.	ne e Area r I	09/16/2012
	(AM) was cond	ucted on 8/17/12 at 2:15					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 2 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SU COMPLET 08/17/20	ΓED	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	P.M When asked how often maintenance repair checks were conducted at the group home, the AM stated, "Monthly." No further documentation was available for review to indicate when the maintenance concerns would be addressed. 9-3-1(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 3 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLI			ETED	
		15G313	B. WIN			08/17/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MISSISSIPPI ST		
ARC OF NORTHWEST INDIANA INC, THE		ANA INC, THE			DN, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	(EACH CORRECTIVE ACTION SHOULD BE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)		DEFICIENCY)		DATE
TAG W0125	483.420(a)(3) PROTECTION O The facility must of clients. Therefore and encourage in their rights as clied citizens of the Unright to file complet process. Based on record 1 of 4 sampled of facility failed to by not obtaining representative or decision maker to decision maker to decisions. Findings included An evening obsetthe group home of P.M. until 6:45 For observation period wheelchair and of bottom and side. A morning obsetthe group home of the group	F CLIENTS RIGHTS ensure the rights of all e, the facility must allow dividual clients to exercise ents of the facility, and as ited States, including the aints, and the right to due review and interview, for lients (client #4), the ensure the client's rights a health care legally sanctioned o assist in medical ervation was conducted at on 8/13/12 from 4:45 P.M During the entire od client #4 sat in his complained of pain to his rvation was conducted at on 8/14/12 from 5:40 A.M During the entire	W0		Client #4 does have family that involved in his medical care. To Community Services Nurse hat re-trained on alternative seating for this client. To ensure future compliance, the Community Services will review repositional charts to ensure that this client repositioned throughout the dat Community Services Nurse and Service Coordinator will visit the home bi-monthly to check for compliance. 9/27/12 This client is in the process of obtaining a guardian through Northwest Indiana Guardiansh Services. All paperwork has be submitted To ensure future compliance, Service Coordinator will ensure that the Health Care Rep for a clients are informed of any changes in medical condition, well as the results of all medical appointments.	t is he as get ing sty. In the sign of the	DATE 09/16/2012
	wheelchair.	day program observation					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 4 of 61

[·			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN			08/17/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF NORTHWEST INDIANA INC, THE				HEBRO	N, IN 46341		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n 8/14/12 from 11:20					
		P.M At 11:45 A.M.,					
		afety Tech (HST) entered					
		xed the day program					
		rofessionals (DSP)s what					
		lressing gets changed.					
		indicated at 2:30 P.M					
	Client #4 sat in h	nis wheelchair during the					
	entire observatio	n period.					
	A review of clien	nt #4's record was					
	conducted at the	facility's administrative					
	office on 8/15/12	2 at 2:15 P.M Review					
	of client #4's Ind	ividual Support Plan					
	(ISP) dated 3/21	/12 indicated: "Legal					
		dividual's Diagnosis:					
		, OBS (Organic Brain					
		teral hip prosthesis,					
		in breakdownWill learn					
	_	edicationWill learn to					
	_	ing staff know he has to					
	use toiletRecei	•					
		es wheelchair with a					
	harness and a she						
		ers)risk plans for					
		nconstipation-receives					
		ll risk plan (due to					
	arthritis). "Gene	• `					
	/	ed 3/21/12 indicated:					
	"Currently taking						
	anticonvulsant a						
		dicationHas had an					
		blem/illness in past 12					
	months, bowel o	bstruction, cellulitis					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 5 of 61

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
MIDILAN	15G313	A. BUILDING	00	08/17/2012
	100010	B. WING	ADDRESS CITY OF THE CORE	30/11/2012
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST	
ARC OF	NORTHWEST INDIANA INC, THE		DN, IN 46341	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCI)	DATE
	(right hand)Receives medication			
	routinely for constipation including			
	suppositories and enemasCod liver			
	oilIs unaware of environmental dangers.			
	Monitored and supervised by			
	staffRequires verbal or physical			
	assistance for transfersOne or more falls			
	in past 12 months. Has Risk PlanHas			
	joint limitations or skeletal			
	deformitiesHas bilateral hip			
	prosthesisSpends 2 hours or more per			
	day in a wheelchair or other mobility			
	device. "Diagnosed with seizure disorder			
	or has new onsetHas risk			
	planCurrently taking more than one			
	medication for seizuresHas a psychiatric			
	diagnosis, Organic Brain			
	SyndromeReceives Geodon as			
	prescribed by neurologistHas or has had			
	chronic health problems /illnesseshas			
	had an acute health problem/illness in			
	past 12 monthshas had an ER			
	(emergency room) visit, admission to			
	outside facility or infirmary for treatment			
	of acute or chronic health problem in past			
	12 months."			
	An interview with the Service			
	Coordinator (SC) was conducted at the			
	facility's administrative office on 8/17/12			
	at 2:00 P.M The SC indicated client #4			
	did not have a Health Care Representative			
	or legally sanctioned decision maker to			
	assist in making medical decisions and			
	<u>I</u>		l	I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 6 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G313	A. BUILDING B. WING	00	COM	E SURVEY PLETED 7/2012
ARC OF	PROVIDER OR SUPPLIER	IANA INC, THE	19038 N	ADDRESS, CITY, STATE, ZIP MISSISSIPPI ST DN, IN 46341	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	was not capable decisions indepe	of making medical indently.				
	9-3-2(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 7 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313			LDING	00	(X3) DATE : COMPL 08/17/	ETED	
	ROVIDER OR SUPPLIER NORTHWEST INDI		•	19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST DN, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0192	training must focu competencies direnteds. Based on observed interview, the factients observed administration (of demonstrating skadminister medical findings include the group home of P.M. until 6:45 Findings	tho work with clients, as on skills and ected toward clients' health acted toward clients' health action, record review and cility failed for 1 of 2 during medication client #2) by staff not cills and competency to cations as prescribed. Envation was conducted at the standard prescribed action 8/13/12 from 4:45 P.M At 5:25 P.M., and his evening prescribed rect Support Professional distered his "Simvastating in) tablet (cholesterol)1 and aday with supper." Entake his medication with At 6:35 P.M., client #2	W0	192	The Community Services, Nur will retrain DSPs on following medication orders, repositionir schedules and pain assessme To ensure future compliance, Community Services Nurse wi visit the home weekly for 3 months and bi-monthly thereat	ng ent. the	09/16/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 8 of 61

	OF CORRECTION IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/17/2012		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE COMPLETION		
	A review of the facility's employee records was conducted on 8/17/12 at 1:00 P.M Review of the employee records failed to indicate any training for any staff who worked at the group home on training and protocol on client #4's repositioning and seating needs, pain assessment and how client #4's wound dressing should be monitored. A second request for staff training records was made on 8/17/12 at 1:45 P.M No training records were submitted for review. An interview with the nurse was conducted on 8/15/12 at 1:15 P.M The nurse indicated staff should administer all medications as prescribed. The nurse further indicated staff should follow directions on medication labels on medication packets. 9-3-3(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 9 of 61

AND PLAN	NT OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIE	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313		OO OOSTRUCTION OO OOSTATE, ZIP OO	— COM	TE SURVEY IPLETED 17/2012
ARC OF	NORTHWEST IND	IANA INC, THE		ON, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W0248	483.440(c)(7) INDIVIDUAL PROA copy of each c	OGRAM PLAN lient's individual plan must le to all relevant staff, other agencies who work and to the client, parents (if nor) or legal guardian. I review and interview, the have updated Individual (SP) for 1 of 3 sampled (SP), available for all staff the facility owned day e: In the same of	W0248	The ISPs were distributed day program and the good by the assigned Individure Compliance, a transport of the ISP will be deversed to maintained by the Lear Coordinator.	group home dual To ensure racking distribution eloped and	09/16/2012
	A review of clie	nt #3's record was				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 10 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 17/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	19038	ADDRESS, CITY, STATE, ZIP (MISSISSIPPI ST DN, IN 46341	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	conducted at the facility's administrative office on 8/15/12 at 2:30 P.M The record indicated a most current ISP dated 3/12/12.				
	An interview with the Service Coordinator (SC) was conducted on 8/17/12 at 2:00 P.M The SC indicated the day program staff should have a current ISP for client #3. 9-3-4(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 11 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		15G313	B. WIN			08/17/	2012
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0249	formulated a clier each client must treatment prograr interventions and number and frequachievement of the individual program interview, the factor written objective opportunity for 3 the group home of the grou	terdisciplinary team has nt's individual program plan, receive a continuous active in consisting of needed services in sufficient uency to support the ne objectives identified in gram plan. ation, record review, and cility failed to implement es during times of 3 of 5 clients residing at (clients #1, #2 and #4).	W0	249	The Service Coordinator will retrain DSPs on implementation of objectives and document training. To ensure future compliance, the Service Coordinator will observe implementation of the program objectives twice monthly for the consecutive months and bi-monthly thereafter.	1	09/16/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 12 of 61

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/17/2012			
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION			
	medications. At 6:25 P.M., client #4 received his evening medications. Client #4 did not learn the 6 rights of medication.						
	A morning observation was conducted at the group home on 8/14/12 from 5:40 A.M. until 7:10 A.M During the entire observation client #1 was not prompted and did not wear his eyeglasses.						
	A facility owned day program observation was conducted on 8/14/12 from 11:20 P.M. until 12:40 P.M During the entire observation period client #1 was not prompted and did not wear his eyeglasses.						
	A review of client #1's record was conducted at the facility's administrative office on 8/15/12 at 12:15 P.M The record indicated a most current Individual Support Plan (ISP) dated 3/5/12 which indicated: "Will increase his self care skills by learning to wear his glasses."						
	A review of client #2's record was conducted at the facility's administrative office on 8/15/12 at 12:50 P.M The record indicated a most current ISP dated 3/29/12 which indicated: "Will identify the 6 rights of two of his medicationswill learn to prepare a main dish."						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 13 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		00	COMPLETED 08/17/2012
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE	332012
ARC OF	NORTHWEST INDIANA INC, THE	HEBRO	N, IN 46341	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	A review of client #4's record was conducted at the facility's administrative office on 8/15/12 at 2:00 P.M The record indicated a most current ISP dated 3/21/12 which indicated: "Will learn the 6 rights of medication." The Service Coordinator (SC) was interviewed on 8/17/12 at 2:00 P.M The SC stated client objectives should be implemented "during all times of opportunity." 9-3-4(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 14 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	a. Building		COMPLETED	
		15G313	A. BUII B. WIN			08/17/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
ADC OF I		ANA INC. THE			MISSISSIPPI ST DN, IN 46341		
ARC OF	NORTHWEST INDI	ANA INC, THE		HEBRU	JN, IN 4034 I		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORR.		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOUL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0331	483.460(c)						
	NURSING SERVI						
	The facility must provide clients with nursing						
	services in accord	dance with their needs.	1110	221			00/16/2012
			W0	331	The Community Services Nurs		09/16/2012
					will review repositioning charts	s to	
	Dagad on magand	marrians abandonian and			ensure that this client is		
		review, observation and			repositioned throughout the da The Community Services Nurs		
		cility failed for 1 of 4			will re-train staff on using pain		
	sampled clients (` *			assessment tools, responding		
	ensuring he received nursing services according to his medical needs.				appropriately to pain and		
					alternative seating for clients in	n	
					wheelchairs. To ensure future)	
	Findings include				compliance, the Community		
	i mamga merade	•			Services Nurse and Service		
	A : C.11 (Carilly In Danie and			Coordinator will visit the home		
		facility's Bureau of			bi-monthly to check progress of wound healing.9/26/12	וכ	
	-	Disability Services			Community Services Nurse		
		was conducted on			re-trained all DSPs to docume	nt	
	8/13/12 at 2:25 P	P.M Review of the			changes in skin condition on the		
	reports indicated	:			Skin Assessment Sheet as we		
	-				as documenting on re-position	ing	
	Report dated 1/3	/12Date of Knowledge:			form. These are sent to the Nu	ırse	
	1/5/12Submitte	•			once a week for review.		
		ail from staff on 1/3/12			To ensure future compliance,		
					Community Services Nurse wi visit the home bi-monthly as w		
	• •	.m. stating that client was			as reviewing sheets for	CII	
		me skin breakdown			completion.		
	around his thigh	areas where the pull ups					
	sits (sic)client	was taken to the Dr. on					
	1/4/12 for an eva	luation with the					
	recommendation	to monitor and follow					
		fter reviewing the					
	-	-					
	statements of peo	-					
		office staff there does not					
		form method of managing					
	[client #4]'s inco	ntinence. During sleep					
I					I		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 15 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G313	B. WIN			08/17/2012	2
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ABC OF	NORTHWEST INDI	IANIA INC. THE			AISSISSIPPI ST IN, IN 46341		
		·			IN, IIN 4034 I	ı	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	601	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	MPLETION DATE
1110		change dry depends	+	0			2.112
		urine and allow [client					
	#4] to sleep. Recommend Nursing staff						
		#4]'s risk and treatment to					
	standardized (sic	_					
	implemented as						
	incontinence risk	-					
	incommence fish	r piwii.					
	Report dated 3/1	6/12 Date of					
	Report dated 3/16/12Date of Knowledge: 3/22/12Submitted Date:						
	3/22/12: "Received an incident report						
	today, 3/22/12 stating that while assisting						
		dressed, staff found an					
	1 2	left buttock cheek. It is					
	small, about the						
	· ·	ospital name Wound					
	Clinic]. New Tr	•					
	_	nent (wound ointment)					
		with a bandage and					
		ently in his wheelchair.					
		for follow-upDescribe					
		being taken to assume					
	l -	issuesThe ulcer is					
	unstageableHa						
	_ ~	njury that keeps him					
		may contribute to ulcer					
		es there is a positioning					
	_	vel of mobility is chair					
		e is a toileting schedule					
		monitored by client.					
	Client states when he is in painThere is						
		cking logStaff have					
		decubitus prevention."					
	I		1			1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 16 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPL	
		15G313	B. WIN	NG		08/17/	2012
NAME OF I	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	DIANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	ervation was conducted at					
	U 1	on 8/13/12 from 4:45					
		P.M. During the entire					
	_	iod client #4 complained					
	-	ottom and side. Direct					
		sional #1 and #2 did not					
	•	at #4's complaints of pain.					
		his wheelchair with no					
		him while he watched					
	television, received his medications and						
		ent #4 was not prompted					
	_	out of his wheelchair and					
	was not repositi	oned.					
	_	ervation was conducted at					
		on 8/14/12 from 5:40					
		A.M During the entire					
		ent #4 sat in his wheelchair					
		beneath him and was not					
	repositioned.						
	1	d day program observation					
		on 8/14/12 from 11:20					
	P.M. until 12:40	P.M During the entire					
	•	iod client #4 sat in his					
	wheelchair with	no cushion and was not					
	repositioned.						
	An interview w	ith client #4 was					
	conducted on 8	/14/12 at 12:20 P.M					
	When asked if he would like to be taken						
	out of his whee	Ichair at his home and					
	while at the day	program, client #4 stated					
	"Yes I would."						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 17 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE COMPL		
		15G313	A. BUI B. WIN	LDING IG		08/17/	2012
	PROVIDER OR SUPPLIER		<u> </u>	19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST IN, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	A review of clie conducted on 8/Review of client Wound clinic no "Wound: 0.7 cm 0.1 cm100% p daily with normal loadingreturn review of the reconstruction of the dressing or documents and color of the dressing or documents at a color of the	nt #4's records was 15/12 at 2:00 P.M #4's record indicated: htation dated 3/20/12: h (centimeters) x 0.4 cm x ale pinkcleanse wound al salineEducation: off in 1 week." Further cord failed to indicate any ment of the size, shape wound, changing of mentation by facility client #4's wound. htation dated 3/27/12: h x 0.6 cm x 0.1 cmNon ial (lowest part of the es of the pelvis) h wound with normal arther review of the record he any nursing the size, shape and color			CROSS-REFERENCED TO THE APPROPRIA	TE	
		nanging of dressing or by facility nursing staff of d.					
	"Wound: 0.9 cn Non healing w with normal sali (antibiotic woun	otation dated 4/3/12: on x 0.7 cm x 0.1 cm roundCleanse wound one dailyBactroban d ointment) twice daily."					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 18 of 61

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY PLETED 7/2012
	PROVIDER OR SUPPLIER		STREET . 19038	ADDRESS, CITY, STATE, ZIP O MISSISSIPPI ST DN, IN 46341	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	size, shape and c changing of dres	sing reassessment of the olor of the wound, sing or documentation by taff of client #4's wound.				
	"Wound: 0.8 cm healing wound normal saline da daily." Further r to indicate any n the size, shape an changing of dres	tation dated 4/10/12: a x 0.4 cm x 0.1 cmNon Cleanse wound with ilyBactroban twice eview of the record failed ursing reassessment of and color of the wound, sing or documentation by taff of client #4's wound.				
	"Patient seen in vound persist. It bactroban. Area switch to santyl cointment)daily normal saline da Further review of indicate any nursize, shape and cochanging of dres	was debrided, will				
	"Wound: 0.7 cm healing wound normal saline da daily." Further r	tation dated 4/24/12: a x 0.4 cm x 0.1 cmNon Cleanse wound with ilyBactroban twice eview of the record failed ursing reassessment of				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 19 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G313	B. WIN	G		08/17/2012
NAME OF D	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDEK OK SUPPLIER			19038 N	/IISSISSIPPI ST	
	NORTHWEST IND	·		HEBRO	N, IN 46341	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)	DATE
		nd color of the wound,				
		sing or documentation by				
	facility nursing staff of client #4's wound.					
	Wound alinia no	station dated 5/1/12:				
	"Wound: 0.4 cm x 0.3 cm x 0.1 cm90%					
	^	ng woundCleanse				
	wound with norr					
	1 -	n twice daily." Further				
	review of the record failed to indicate any					
	nursing reassessment of the size, shape					
	and color of the	wound, changing of				
	dressing or docu	mentation by facility				
	nursing staff of o	client #4's wound.				
	Wound clinic no	tation dated 5/8/12:				
	"Wound: 0.4 cm	n x 0.3 cm x 0.1				
	cmHealing wo	undSeven				
	dayAquacel (w	vound dressing)Do not				
		et." Further review of the				
	~	ndicate any nursing				
		the size, shape and color				
		anging of dressing or				
	•	by facility nursing staff of				
	client #4's wound					
	enent #4 8 would	u.				
	Wound clinic no	station dated 5/15/12:				
		1 x 0.3 cm x 0.1 cmNon				
		Cleanse wound with				
	normal salineChange every 3					
	daysHydrocollord (wound dressing)."					
	Further review of the record failed to					
	I	sing reassessment of the				
	size, shape and c	color of the wound,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 20 of 61

	TOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTII A. BUILDIN B. WING		00	(X3) DATE (COMPL 08/17/	ETED
	PROVIDER OR SUPPLIER		ST 19	038 M	DDRESS, CITY, STATE, ZIP CODE IISSISSIPPI ST N, IN 46341	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	"	sing or documentation by taff of client #4's wound.					
	"Wound: 0.6 cm cmCleanse with every 3 daysH Off loading." Furecord failed to in reassessment of the wound, ch	h normal salineChange ydrocollordEducation: urther review of the ndicate any nursing the size, shape and color anging of dressing or y facility nursing staff of					
	"Wound: 1.0 cm cm100% pink. woundLidocair ointmentSeven dressingSantyl wetHydrofera dressing)Educa wheelchair while of the record fail nursing reassessi and color of the dressing or docu	superficialNon healing ne 5% topical day Do not remove or get					
	"Poorly healing x 0.1 cmPoorly day dressingSa	tation dated 6/5/12: wound 0.5 cm x 0.5 cm healing woundSeven antylDo not remove or era Blue." Further review					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 21 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		08/17/	2012
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ed to indicate any					
	nursing reassessment of the size, shape						
		wound, changing of					
	dressing or documentation by facility nursing staff of client #4's wound.						
	Wound clinic notation dated 6/12/12:						
	"Non healing wo	ound 0.9 cm x 0.5 cm x					
	0.1 cmSuperfic	cial paleCleanse wound					
	with normal saline, change dressing every						
	other dayAquacelChange outer						
		d." Further review of the					
	record failed to i	ndicate any nursing					
		the size, shape and color					
		anging of dressing or					
		y facility nursing staff of					
	client #4's wound						
	Cheffit #43 Would	u.					
	Wound clinic no	tation dated 6/21/12:					
		ound 0.8 cm x 0.8 cm x					
		ale pink woundPoorly					
	-	Cleanse wound with					
	_						
	normal saline da						
		el." Further review of the					
		ndicate any nursing					
		the size, shape and color					
		anging of dressing or					
	documentation by facility nursing staff of						
	client #4's wound	d.					
	Wound clinic notation dated 7/12/12:						
		wound 0.9 cm x 0.7 cm					
	· ·	y healing woundSeven					
	day dressingSa	antylDo not remove or					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 22 of 61

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		A. BUILDING	00	CON	(X3) DATE SURVEY COMPLETED 08/17/2012	
	PROVIDER OR SUPPLIER		1903	ET ADDRESS, CITY, STATE, ZIP 8 MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE	HEBI	RON, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	of the record fail nursing reassess and color of the dressing or docu	Pera Blue." Further review led to indicate any ment of the size, shape wound, changing of mentation by facility client #4's wound.				
	"Non healing wo 0.1 cmNon hea paleSantylDo wetHydrofera the record failed reassessment of of the wound, ch	patation dated 7/19/12: bund 0.6 cm x 0.5 cm x aling wound100% o not remove or get Blue." Further review of to indicate any nursing the size, shape and color tanging of dressing or by facility nursing staff of d.				
	"Non healing wo 0.1 cmPaleN woundSeven d (wound dressing Further review o indicate any nurs size, shape and o changing of dres facility nursing s	tration dated 7/26/12: bund 0.5 cm x 0.5 cm x fon healing lay dressingIdoflex pad b)Do not remove." of the record failed to sing reassessment of the color of the wound, ssing or documentation by staff of client #4's wound. tration dated 8/2/12: wound 1 cm x 0.8 cm x				
	0.1 cmPaleN woundApply c					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 23 of 61

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 00	l í	TE SURVEY MPLETED	
711.12 11.111	or conduction	15G313	A. BUILDING			17/2012	
			B. WING	ADDRESS, CITY, STATE, ZII	_	- -	
NAME OF I	PROVIDER OR SUPPLIER	R		MISSISSIPPI ST	CODE		
ARC OF	NORTHWEST IND	IANA INC, THE		N, IN 46341			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL SLSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	HE APPROPRIATE	COMPLETION DATE	
TAG		ellerate from wound bed	TAG		,	DATE	
		re on each dressing."					
		of the record failed to					
		sing reassessment of the					
	_	color of the wound,					
	_	ssing or documentation by					
	1	•					
	facility nursing staff of client #4's wound.						
	Wound clinic notation dated 8/9/12:						
		ound 0.8 cm x 0.4 cm x					
		healing woundSeven					
	1	antylDo not remove or					
	1 -	Fera Blue." Further review					
	1 -	led to indicate any					
		ment of the size, shape					
	_	wound, changing of					
		mentation by facility					
	_	client #4's wound.					
	nursing starr or o	chent #45 wound.					
	A confidential in	nterview with DSPs #16					
	and #17 was cor	nducted. DSP #16 stated					
	"I don't know ho	ow they expect [client #4]					
	to heal when the	ey never get him out of his					
	wheelchair. Wh	en asked if client #4 had					
	a repositioning s	schedule/alternative					
	seating schedule	e, both DSP #16 and #17					
	stated "No." WI	hen asked if staff					
	documented bod	ly checks on client #4,					
	both DSP #16 aı	nd #17 stated "No."					
	When asked if the	hey were trained on how					
	to care for client #4's wound, DSPs #16						
	and #17 stated "	No." When asked if there					
	was a pain asses	sment tool used to					
	monitor client #4	4's complaints of pain,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 24 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G313	B. WIN			08/17/2	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
4DC 0E	NODELIMEST IND	IANIA INIC. THE			MISSISSIPPI ST		
	NORTHWEST IND			HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		and #17 stated "No."		IAG	,		DATE
		ursing staff changes					
		d bandaging, DSPs #16					
	and #17 stated "						
	and #1/ Stated	NO.					
	A review of the	facility's employee					
		ducted on 8/17/12 at 1:00					
		f the employee records					
		e any training for any staff					
		he group home and the					
		ay program on training					
	<u>-</u>	client #4's repositioning					
	_	s, pain assessment and					
		vound dressing should be					
	monitored.	young ground of					
	momtored.						
	An interview wi	th the group home nurse					
		n 8/15/12 at 2:25 P.M					
	The nurse stated	"This Sunday was the					
		to the group home and I					
	discovered there	are things that need to be					
	in place for [clie	nt #4]." The nurse					
	indicated there v	vas no documentation					
	available for rev	iew to indicate a					
	repositioning/alt	ernative seating schedule					
	for client #4. Th	e nurse also indicated					
	there was no doo	cumentation available for					
	review to indicat	te staff conducted body					
		#4 to check for skin					
	break down. Wh	nen asked if there was a					
		tool used for client #4's					
		in, the nurse indicated					
		When asked if there was					
	any documentati	on available for review to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 25 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G313	A. BUILDING B. WING	00	COMPLETED 08/17/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	were trained on I indicated there w there was any do review to indicat and changed dre	working with client #4 his medical needs, she vas not. When asked if becumentation available for the nursing staff monitored ssing of client #4's the answered "No."						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 26 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		15G313	A. BUII B. WIN			08/17/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ADC OF	NODTUMEST INDI	ANA INC. THE			MISSISSIPPI ST		
ARC OF	NORTHWEST INDI	ANA INC, THE	HEBRON,		JN, IN 4654 I		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0334	clients certified as	must include, for those s not needing a medical w of their health status	W0:	334	Community Services Nurse wi visit the group home weekly to	1	09/16/2012
	interview, the factor nursing services examinations for health conditions (client #4) who represent the factor of	facility's Bureau of Disability Services was conducted on P.M Review of the : /12Date of Knowledge:			assess healing progress of this wound. The Community Service Nurse will also review the repositioning sheets to ensure client is receiving alternate seating. To ensure future compliance, the Community Services Nurse will visit the howeekly until wound heals and eleast bi-monthly thereafter. 9/27/12Community Services Nurse re-trained all DSPs to document changes in skin condition on the Skin Assessm Sheet as well as documenting re-positioning form. These are sent to the Nurse once a week review. To ensure future compliance, the Community Services Nurse will visit the hobi-monthly as well as reviewing sheets for completion.	sces ome at nent on sfor	
	at approx. 9:00 a starting to get so around his thigh sits (sic)client 1/4/12 for an eva	nail from staff on 1/3/12 n.m. stating that client was me skin breakdown areas where the pull ups was taken to the Dr. on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 27 of 61

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G313		LDING	NSTRUCTION 00	(X3) DATE COMPL 08/17/	ETED	
	PROVIDER OR SUPPLIER		19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	statements of per Mississippi and of seem to be a unit [client #4]'s inco time some staff of others check for #4] to sleep. Refevaluate [client # standardized (sic implemented as incontinence risk. Report dated 3/1 Knowledge: 3/2 3/22/12: "Receiveday, 3/22/12 st [client #4] to get open sore on his small, about the tackSent to [Hoch Clinic]. New Treposition frequence actions health and safety unstageableHa orthopedic hip in immobile which developmentY scheduleHis le	office staff there does not form method of managing ntinence. During sleep change dry depends urine and allow [client commend Nursing staff [44]'s risk and treatment to a schedule be part of his skin a plan." 6/12Date of 2/12Submitted Date: wed an incident report ating that while assisting dressed, staff found an left buttock cheek. It is size of a thumb cospital name Wound eatment: apply ment (wound ointment) with a bandage and ently in his wheelchair. For follow-upDescribe being taken to assume a issuesThe ulcer is				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 28 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	IG		08/17/	2012
NAME OF I	PROVIDER OR SUPPLIEF	}			ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	monitored by client.					
		en he is in painThere is					
		cking logStaff have					
	been trained on	decubitus prevention."					
	An evening obse	ervation was conducted at					
	the group home	on 8/13/12 from 4:45					
	P.M. until 6:45 I	P.M During the entire					
	observation peri	od client #4 complained					
	of pain to his bo	ttom and side. Direct					
	Support Professi	ional #1 and #2 did not					
	respond to client	t #4's complaints of pain.					
	Client #4 sat in l	his wheelchair with no					
	cushion beneath	him while he watched					
	television, receiv	ved his medications and					
	· ·	nt #4 was not prompted					
		out of his wheelchair and					
	was not reposition						
	was not repositiv	siled.					
	A morning obse	rvation was conducted at					
		on 8/14/12 from 5:40					
		A.M During the entire					
		nt #4 sat in his wheelchair					
		beneath him and was not					
		beneath min and was not					
	repositioned.						
	A facility average	1 day program abasemetics					
		day program observation					
		on 8/14/12 from 11:20					
		P.M. During the entire					
	1	od client #4 sat in his					
		no cushion and was not					
	repositioned.						
	An interview wi	th client #4 was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 29 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		08/17/	2012
NAME OF F	PROVIDER OR SUPPLIEF	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					AISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		14/12 at 12:20 P.M					
		e would like to be taken					
	out of his wheel	chair at his home and					
	while at the day	program, client #4 stated					
	"Yes I would."						
	A review of clie	nt #4's records was					
	conducted on 8/	15/12 at 2:00 P.M					
	Review of client	t #4's record indicated:					
	Wound clinic no	otation dated 3/20/12:					
	"Wound: 0.7 cn	n (centimeters) x 0.4 cm x					
		ale pinkcleanse wound					
	_	al salineEducation: off					
		in 1 week." Further					
		cord failed to indicate any					
		ment of the size, shape					
		wound, changing of					
	_	imentation by facility					
	nursing starr or o	client #4's wound.					
	W 1 -1''	4-4: 1-4-12/27/12-					
		otation dated 3/27/12:					
		n x 0.6 cm x 0.1 cmNon					
	_	ial (lowest part of the					
	three major bone	* *					
		e wound with normal					
	saline daily." Fu	urther review of the record					
	failed to indicate	e any nursing					
	reassessment of	the size, shape and color					
	of the wound, ch	nanging of dressing or					
		by facility nursing staff of					
	client #4's woun						
	Wound clinic no	otation dated 4/3/12:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 30 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE C A. BUILDING B. WING	OONSTRUCTION OO	COM	E SURVEY PLETED 7/2012	
	PROVIDER OR SUPPLIER		STREET 19038	CADDRESS, CITY, STATE, ZIP O MISSISSIPPI ST ON, IN 46341	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Non healing w with normal salin (antibiotic woun Further review or indicate any nursize, shape and cochanging of dress facility nursing some wound clinic non "Wound: 0.8 cm healing wound normal saline dated daily." Further into indicate any inthe size, shape and changing of dress facility nursing some wound persist. It bactroban. Area switch to Santyl ointment) daily normal saline date Further review of indicate any nursize, shape and cochanging of dress facility nursing some size, shape and cochanging of dress facility nursing some saline date facility nursing some saline date facility nursing some saline saline date facility nursing some saline saline saline date facility nursing some saline sali	oundCleanse wound ne dailyBactroban d ointment) twice daily." If the record failed to sing reassessment of the olor of the wound, sing or documentation by taff of client #4's wound. tation dated 4/10/12: 1 x 0.4 cm x 0.1 cmNon Cleanse wound with ilyBactroban twice eview of the record failed ursing reassessment of and color of the wound, sing or documentation by taff of client #4's wound. tation dated 4/19/12: wound clinic, left ischial Have been using was debrided, will (antibiotic woundCleanse wound with ilySantyl daily." If the record failed to sing reassessment of the olor of the wound, sing or documentation by taff of client #4's wound. tation dated 4/24/12:				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 31 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		08/17/	2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			19038 M	/IISSISSIPPI ST		
	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n x 0.4 cm x 0.1 cmNon					
	~	Cleanse wound with					
		ilyBactroban twice					
	daily." Further i	review of the record failed					
	to indicate any n	ursing reassessment of					
	the size, shape a	nd color of the wound,					
	changing of dres	sing or documentation by					
	facility nursing s	staff of client #4's wound.					
	Wound clinic no	tation dated 5/1/12:					
	"Wound: 0.4 cn	n x 0.3 cm x 0.1 cm90%					
	pinkNon heali	ng woundCleanse					
	wound with norn	nal saline					
	dailyBactrobar	n twice daily." Further					
	I -	cord failed to indicate any					
		ment of the size, shape					
	_	wound, changing of					
	~	mentation by facility					
	nursing staff of o	elient #4's wound.					
	Wound clinic no	tation dated 5/8/12:					
	"Wound: 0.4 cm	1 x 0.3 cm x 0.1					
	cmHealing wo						
	1	yound dressing)Do not					
	l • • •	et." Further review of the					
		ndicate any nursing					
		the size, shape and color					
		-					
		anging of dressing or					
		y facility nursing staff of					
	client #4's woun	a.					
	Wound clinic no	tation dated 5/15/12:					
		1 x 0.3 cm x 0.1 cmNon					
		Cleanse wound with					
	incaring wound	Cleanse would will		l			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 32 of 61

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			IULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLI	
		15G313	B. WIN	NG		08/17/	2012
NAME OF I	PROVIDER OR SUPPLIE		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIE	N.		19038 N	MISSISSIPPI ST		
ARC OF	NORTHWEST IND	IANA INC, THE		HEBRO	N, IN 46341		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	normal saline(
	daysHydrocol	lord (wound dressing)."					
	Further review of	of the record failed to					
	indicate any nur	rsing reassessment of the					
	size, shape and	color of the wound,					
	changing of dres	ssing or documentation by					
	facility nursing	staff of client #4's wound.					
	Wound clinic no	otation dated 5/22/12:					
	"Wound: 0.6 cr	n x 0.4 cm x 0.1					
		th normal salineChange					
		[ydrocollordEducation:					
		urther review of the					
		indicate any nursing					
		the size, shape and color					
	•	hanging of dressing or					
		by facility nursing staff of					
	client #4's woun	id.					
	Wound clinic no	otation dated 5/29/12:					
	"Wound: 1.0 cm						
		superficialNon healing					
	woundLidocai	_					
	ointmentSevei	•					
		lDo not remove or get					
	wetHydrofera	_					
	_	*					
	J 27	ation: Use cushion in					
		e sitting." Further review					
		led to indicate any					
	_	ment of the size, shape					
		wound, changing of					
		mentation by facility					
	nursing staff of	client #4's wound.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 33 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI	
AND PLAN	OF CORRECTION	15G313		LDING	00	08/17/2	
		100010	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/11/1	
NAME OF P	PROVIDER OR SUPPLIER	l .			MISSISSIPPI ST		
	NORTHWEST INDI			HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1110		tation dated 6/5/12:		0			5.1.12
	"Poorly healing wound 0.5 cm x 0.5 cm						
		y healing woundSeven					
		antylDo not remove or					
		era Blue." Further review					
	"	ed to indicate any					
		ment of the size, shape					
		wound, changing of					
	dressing or docu	mentation by facility					
	nursing staff of c	client #4's wound.					
	Wound clinic no	tation dated 6/12/12:					
	"Non healing wo	ound 0.9 cm x 0.5 cm x					
	0.1 cmSuperfic	cial paleCleanse wound					
	with normal salin	ne, change dressing every					
	other dayAqua	celChange outer					
	dressing if soiled	d." Further review of the					
		ndicate any nursing					
		the size, shape and color					
	· ·	anging of dressing or					
		y facility nursing staff of					
	client #4's wound	d.					
	Wound clinic no	tation dated 6/21/12:					
		ound 0.8 cm x 0.8 cm x					
	_	ale pink woundPoorly					
	_	Cleanse wound with					
	normal saline da						
	loadingAquacel." Further review of the record failed to indicate any nursing						
	reassessment of the size, shape and color						
	of the wound, changing of dressing or						
	· · · · · · · · · · · · · · · · · · ·	by facility nursing staff of					
	client #4's wound						
	I		ı				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 34 of 61

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313			TIPLE CO	NSTRUCTION 00	(X3) DATE S COMPLE 08/17/2	ETED
		100313	B. WING	1		00/17/2	2012
NAME OF I	PROVIDER OR SUPPLIE	3			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			MISSISSIPPI ST N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORY OF	LISC IDENTIFYING INFORMATION)	+	IAG	BEI ICIENCT)		DATE
	Wound alinia na	otation dated 7/12/12:					
	_	wound 0.9 cm x 0.7 cm y healing woundSeven					
	· '						
	1 -	antylDo not remove or					
	1 -	Fera Blue." Further review					
		led to indicate any					
	_	ment of the size, shape					
		wound, changing of					
	_	mentation by facility					
	nursing starr or o	client #4's wound.					
	Wound alinia na	otation dated 7/19/12:					
	_	ound 0.6 cm x 0.5 cm x					
		aling wound100%					
	-	o not remove or get					
	1	Blue." Further review of					
		to indicate any nursing					
		the size, shape and color					
		nanging of dressing or					
		by facility nursing staff of					
	client #4's woun	a.					
	Wound alinia	otation dated 7/26/12:					
		ound 0.5 cm x 0.5 cm x					
	0.1 cmPaleN	•					
		lay dressingIdoflex pad					
		g)Do not remove."					
		of the record failed to					
	<u> </u>	sing reassessment of the					
	_	color of the wound,					
	1	ssing or documentation by					
	facility nursing	staff of client #4's wound.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 35 of 61

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 08/17/	ETED
	PROVIDER OR SUPPLIER			19038 N	DDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	"Poorly healing of the mursing reassess and color of the dressing or documursing staff of color and the murse indicate of the nurse indicate of the nurse indicate of the documentation who changes in client to determine who changes in client to determine who changes in client to do continuous to determine who changes in client to determine who changes in client to do continuous to determine who changes in client to do continuous to determine who changes in client to do continuous to do the documentation of th	ellerate (antibiotic and bed every other day, ellerate from wound bed e on each dressing." If the record failed to sing reassessment of the color of the wound, sing or documentation by staff of client #4's wound. Itation dated 8/9/12: Found 0.8 cm x 0.4 cm x nealing woundSeven antylDo not remove or tera Blue." Further review ed to indicate any ment of the size, shape wound, changing of mentation by facility client #4's wound. Ith the group home nurse in 8/15/12 at 2:25 P.M ted no facility staff					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 36 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP: 08/17	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET A 19038 N	ADDRESS, CITY, STATE, ZIP CO MISSISSIPPI ST IN, IN 46341	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	indicated the facility group home staff and day program staff changed client #4's wound dressings, and indicated no facility documentation nor facility monitoring system of direct physical examinations for client #4's skin breakdown was available for review. 9-3-6(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 37 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00 COMPL			ETED	
		15G313	B. WIN			08/17/	2012
C OF P					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			19038 N	MISSISSIPPI ST		
	NORTHWEST INDI	ANA INC, THE		HEBRO	DN, IN 46341		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
W0338	clients certified as care plan, a revie which must result (including referral client health prob	must include, for those is not needing a medical work of their health status in any necessary action to a physician to address lems).	W0.	338	The Community Services Nurs will review repositioning charts ensure that this client is repositioned throughout the da	s to ay.	09/16/2012
	interview, the fact failed for 1 of	facility's Bureau of Disability Services was conducted on P.M Review of the			The Community Services Nurse will re-train staff on using pain assessment tools, responding appropriately to pain and alternative seating for clients in wheelchairs. Community Servi Nurse will visit the group home weekly to assess healing progress of this wound. The Community Services Nurse will also review the repositioning sheets to ensure client is receiving alternate seating. To ensure future compliance, the Community Services Nurse will visit the home weekly until wou heals, and at least bi-monthly thereafter.	ces	
	1/5/12Submitted "Received an emat approx. 9:00 a starting to get so around his thigh sits (sic)client 1/4/12 for an evaluation	mail from staff on 1/3/12 .m. stating that client was me skin breakdown areas where the pull ups was taken to the Dr. on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 38 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00	r '	TE SURVEY IPLETED	
		15G313	A. BUILDING B. WING			17/2012
				ADDRESS, CITY, STATE, ZIP		
NAME OF F	PROVIDER OR SUPPLIEF	₹		MISSISSIPPI ST		
	NORTHWEST IND		HEBRO	N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
1710		fter reviewing the	1710	<u> </u>		DATE
	statements of pe	· ·				
		office staff there does not				
		form method of managing				
		ontinence. During sleep				
		change dry depends				
		urine and allow [client				
		commend Nursing staff				
		#4]'s risk and treatment to				
	standardized (sic) a schedule be					
	implemented as part of his skin					
	incontinence risk plan."					
		Γ				
	Report dated 3/1	6/12Date of				
	Knowledge: 3/2	22/12Submitted Date:				
	3/22/12: "Recei	ved an incident report				
	today, 3/22/12 st	tating that while assisting				
	[client #4] to get	t dressed, staff found an				
	open sore on his	left buttock cheek. It is				
	small, about the	size of a thumb				
	tackSent to [H	ospital name Wound				
	Clinic]. New Tr	reatment: apply				
		ment (wound ointment)				
	1 -	with a bandage and				
		ently in his wheelchair.				
		for follow-upDescribe				
	*	being taken to assume				
	ľ	y issuesThe ulcer is				
	unstageableHa	•				
		njury that keeps him				
		may contribute to ulcer				
	_	es there is a positioning				
		evel of mobility is chair				
	boundYes ther	re is a toileting schedule				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 39 of 61

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA I OF CORRECTION IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CC	00	COM	TE SURVEY MPLETED 17/2012
	130010	B. WING	ADDRESS, CITY, STATE, ZIP (11/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	19038 N	MISSISSIPPI ST DN, IN 46341	LODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	in placePain is monitored by client. Client states when he is in painThere is no decubitus tracking logStaff have been trained on decubitus prevention."				
	An evening observation was conducted at the group home on 8/13/12 from 4:45 P.M. until 6:45 P.M During the entire observation period client #4 complained of pain to his bottom and side. Direct Support Professional #1 and #2 did not respond to client #4's complaints of pain. Client #4 sat in his wheelchair with no cushion beneath him while he watched television, received his medications and ate dinner. Client #4 was not prompted and did not get out of his wheelchair and was not repositioned.				
	A morning observation was conducted at the group home on 8/14/12 from 5:40 A.M. until 7:10 A.M During the entire observation client #4 sat in his wheelchair with no cushion beneath him and was not repositioned.				
	A facility owned day program observation was conducted on 8/14/12 from 11:20 P.M. until 12:40 P.M During the entire observation period client #4 sat in his wheelchair with no cushion and was not repositioned.				
	An interview with client #4 was				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 40 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	COM	E SURVEY PLETED 7/2012	
	PROVIDER OR SUPPLIER		19038	ADDRESS, CITY, STATE, ZIP MISSISSIPPI ST DN, IN 46341	CODE	
(X4) ID PREFIX	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
PREFIX TAG	conducted on 8/1 When asked if he out of his wheeld while at the day "Yes I would." A review of client conducted on 8/1 Review of client Wound clinic no "Wound: 0.7 cm 0.1 cm100% pedaily with normal loadingreturn is review of the reconursing reassess and color of the dressing or documursing staff of color wound: 0.8 cm "Wound: 0.8 cm"	LISC IDENTIFYING INFORMATION) 4/12 at 12:20 P.M e would like to be taken chair at his home and program, client #4 stated at #4's records was 5/12 at 2:00 P.M #4's record indicated: tation dated 3/20/12: a (centimeters) x 0.4 cm x ale pinkcleanse wound al salineEducation: off an 1 week." Further ord failed to indicate any ment of the size, shape wound, changing of mentation by facility client #4's wound. tation dated 3/27/12: a x 0.6 cm x 0.1 cmNon	PREFIX TAG	CROSS-REFERENCED TO THE		COMPLETION DATE
	three major bone woundCleanse saline daily." Fu failed to indicate reassessment of of the wound, ch documentation b client #4's wound	wound with normal arther review of the record any nursing the size, shape and color anging of dressing or y facility nursing staff of				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 41 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		08/17/	2012
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
					/IISSISSIPPI ST		
ARC OF NORTHWEST INDIANA INC, THE				HEBRO	N, IN 46341		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		1 x 0.7 cm x 0.1 cm					
		oundCleanse wound					
		ne dailyBactroban					
	*	d ointment) twice daily."					
		f the record failed to					
		sing reassessment of the					
	_	color of the wound,					
		sing or documentation by					
	facility nursing s	staff of client #4's wound.					
	Wound clinic notation dated 4/10/12:						
		1 x 0.4 cm x 0.1 cmNon					
		Cleanse wound with					
	_	ilyBactroban twice					
		review of the record failed					
		ursing reassessment of					
	1	nd color of the wound,					
		sing or documentation by					
		staff of client #4's wound.					
	facility hursing s	tall of chefit #45 would.					
		tation dated 4/19/12:					
	"Patient seen in	wound clinic, left ischial					
	wound persist. I	Have been using					
	bactroban. Area	was debrided, will					
	switch to Santyl	(antibiotic wound					
	ointment) daily	.Cleanse wound with					
	normal saline da	ilySantyl daily."					
	Further review o	f the record failed to					
	indicate any nurs	sing reassessment of the					
	size, shape and c	olor of the wound,					
	changing of dres	sing or documentation by					
		staff of client #4's wound.					
	Wound clinic no	tation dated 4/24/12:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 42 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	G		08/17/	2012
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SULLEIE			19038 N	MISSISSIPPI ST		
ARC OF NORTHWEST INDIANA INC, THE					N, IN 46341		
(X4) ID	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX TAG				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TE	COMPLETION DATE
TAG		<u> </u>		TAG	BETTELLINETY		DATE
		n x 0.4 cm x 0.1 cmNon					
		.Cleanse wound with					
		nilyBactroban twice					
	_	review of the record failed					
		nursing reassessment of					
		nd color of the wound,					
		ssing or documentation by					
	facility nursing	staff of client #4's wound.					
	Wound clinic notation dated 5/1/12:						
	"Wound: 0.4 cm x 0.3 cm x 0.1 cm90%						
	-	ng woundCleanse					
	wound with nor						
	dailyBactroba	n twice daily." Further					
	review of the red	cord failed to indicate any					
	nursing reassess	ment of the size, shape					
	and color of the	wound, changing of					
	dressing or docu	mentation by facility					
	nursing staff of	client #4's wound.					
	Wound alinia	station dated 5/9/12:					
		otation dated 5/8/12:					
	"Wound: 0.4 cm						
	cmHealing wo						
		vound dressing)Do not					
		et." Further review of the					
		indicate any nursing					
		the size, shape and color					
	· · · · · · · · · · · · · · · · · · ·	nanging of dressing or					
		by facility nursing staff of					
	client #4's woun	d.					
	Wound clinic no	otation dated 5/15/12:					
		n x 0.3 cm x 0.1 cmNon					
		.Cleanse wound with					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 43 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313			(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/17/2012
	PROVIDER OR SUPPLIEI NORTHWEST IND		19038	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST ON, IN 46341	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Further review of indicate any nursize, shape and of changing of dress facility nursing states. Wound clinic not "Wound: 0.6 cmCleanse wirevery 3 daysH Off loading." For record failed to reassessment of of the wound, changed the client #4's wound Wound clinic not "Wound: 1.0 cm100% pink, wound Lidocai ointment Sever dressing Santy wet Hydrofera dressing) Educ wheelchair while of the record failed to reassess and color of the dressing or documents	lord (wound dressing)." of the record failed to sing reassessment of the color of the wound, ssing or documentation by staff of client #4's wound. otation dated 5/22/12: on x 0.4 cm x 0.1 th normal salineChange sydrocollordEducation: urther review of the indicate any nursing the size, shape and color hanging of dressing or by facility nursing staff of d. otation dated 5/29/12: on x 0.5 cm x 0.1 superficialNon healing the 5% topical of day lDo not remove or get			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 44 of 61

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPL 08/17/	ETED
	PROVIDER OR SUPPLIER			19038 M	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST IN, IN 46341	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	"Poorly healing x 0.1 cmPoorly day dressingSa get wetHydrof of the record fail nursing reassess and color of the dressing or docu nursing staff of color wound clinic no "Non healing wo 0.1 cmSuperfice with normal saling other dayAquadressing if soiled record failed to it reassessment of of the wound, che documentation be client #4's wound wound clinic no "Non healing wo 0.1 cm100% pe healing wound normal saline da loadingAquace record failed to it reassessment of of the wound, che color wound, che wound, che color wound, che wound, che color wound, che wound, che wound, che wound, che wound, che wound, che color wound, che wound which wound w	tation dated 6/21/12: bund 0.8 cm x 0.8 cm x ale pink woundPoorly Cleanse wound with ilySantylOff el." Further review of the indicate any nursing the size, shape and color langing of dressing or y facility nursing staff of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 45 of 61

	OF CORRECTION OF CORRECTION 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/17/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
	Wound clinic notation dated 7/12/12: "Poorly healing wound 0.9 cm x 0.7 cm x 0.1 cmPoorly healing woundSeven day dressingSantylDo not remove or get wetHydrofera Blue." Further review of the record failed to indicate any nursing reassessment of the size, shape and color of the wound, changing of dressing or documentation by facility nursing staff of client #4's wound. Wound clinic notation dated 7/19/12: "Non healing wound 0.6 cm x 0.5 cm x 0.1 cmNon healing wound100% paleSantylDo not remove or get wetHydrofera Blue." Further review of the record failed to indicate any nursing reassessment of the size, shape and color of the wound, changing of dressing or documentation by facility nursing staff of client #4's wound. Wound clinic notation dated 7/26/12: "Non healing wound 0.5 cm x 0.5 cm x 0.1 cmPaleNon healing woundSeven day dressingIdoflex pad (wound dressing)Do not remove." Further review of the record failed to indicate any nursing reassessment of the size, shape and color of the wound, changing of dressing or documentation by facility nursing staff of client #4's wound.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 46 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		15G313	B. WIN			08/17/	/2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			MISSISSIPPI ST		
ARC OF	NORTHWEST IN	DIANA INC, THE			N, IN 46341		
(X4) ID	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY		DATE
		otation dated 8/2/12:					
		g wound 1 cm x 0.8 cm x					
	0.1 cmPale1	•					
	woundApply	cellerate (antibiotic					
	ointment) to wo	ound bed every other day,					
	do not remove	cellerate from wound bed					
	just reapply mo	re on each dressing."					
	Further review	of the record failed to					
	indicate any nu	rsing reassessment of the					
	-	color of the wound,					
changing of dressing or documentation by							
		staff of client #4's wound.					
	Wound clinic n	otation dated 8/9/12:					
		yound 0.8 cm x 0.4 cm x					
	_	healing woundSeven					
	1	SantylDo not remove or					
		fera Blue." Further review					
	1 -	iled to indicate any					
	_	sment of the size, shape					
		e wound, changing of					
	_	umentation by facility					
	nursing staff of	client #4's wound					
	An interview w	ith the group home nurse					
		on 8/15/12 at 2:25 P.M					
		d "This Sunday was the					
		t to the group home and I					
	discovered there are things that need to be						
in place for [client #4]." The nurse							
	indicated there was no documentation available for review to indicate a						
	-	Iternative seating schedule					
for client #4. The nurse also indicated							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 47 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/17/2012			
	PROVIDER OR SUPPLIE		STREET . 19038	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST DN, IN 46341	
(X4) ID PREFIX TAG	(EACH DEFICIENT OF REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	review to indicate checks on clients break down. We pain assessment complaints of pathere was not. Any documentate indicate all staffs were trained on indicated there was any dereview to indicate and changed dreams.	cumentation available for the staff conducted body at #4 to check for skin then asked if there was a tool used for client #4's ain, the nurse indicated When asked if there was ion available for review to working with client #4 this medical needs, she was not. When asked if occumentation available for the nursing staff monitored tessing of client #4's the enswered "No."			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 48 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/17/2012		
	PROVIDER OR SUPPLIER			19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST N, IN 46341		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0340	with other member team, appropriate health measures limited to training in appropriate health measures limited to training in appropriate health care needs clients (client #4 Findings include A review of the frequency of the	must include implementing ers of the interdisciplinary protective and preventive that include, but are not clients and staff as needed alth and hygiene methods. review, observation and cility nursing services taff were trained in s for 1 of 4 sampled). facility's Bureau of Disability Services was conducted on P.M Review of the : /12Date of Knowledge: ed Date: 1/6/12: eail from staff on 1/3/12m. stating that client was me skin breakdown areas where the pull ups aken to the Dr. on 1/4/12 is with the to monitor and follow fter reviewing the	W0:	340	The Community Services Nurse will review repositioning charts ensure that this client is repositioned throughout the data The Community Services Nurse will re-train staff on using pain assessment tools, responding appropriately to pain and alternative seating for clients is wheelchairs. Community Serv Nurse will visit the group home weekly to assess healing progress of this wound. The Community Services Nurse will also review the repositioning sheets to ensure client is receiving alternate seating. To ensure future compliance, the Community Services Nurse wivisit the home weekly until wo heals, and at least bi-monthly thereafter.	s to ay. se n ices e	09/16/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 49 of 61

	OF CORRECTION OF CORRECTION 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	08/17/2012			
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION		
	Mississippi and office staff there does not seem to be a uniform method of managing [client #4]'s incontinence. During sleep time some staff change dry depends others check for urine and allow [client #4] to sleep. Recommend Nursing staff evaluate [client #4]'s risk and treatment to standardized (sic) a schedule be implemented as part of his skin incontinence risk plan." Report dated 3/16/12Date of Knowledge: 3/22/12Submitted Date: 3/22/12: "Received an incident report today, 3/22/12 stating that while assisting [client #4] to get dressed, staff found an open sore on his left buttock cheek. It is small, about the size of a thumb tackSent to Methodist Wound Clinic. New Treatment: apply Bacitracin Ointment daily and cover with a bandage and reposition frequently in his wheelchair. Return 3/27/12 for follow-upDescribe systemic actions being taken to assume health and safety issuesThe ulcer is unstageableHas a diagnosis of orthopedic hip injury that keeps him immobile which may contribute to ulcer developmentYes there is a positioning scheduleHis level of mobility is chair boundYes there is a toileting schedule in placePain is monitored by client. Client states when he is in painThere is no decubitus					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 50 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN			08/17/	2012
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
					MISSISSIPPI ST		
ARC OF NORTHWEST INDIANA INC, THE				HEBRO	N, IN 46341		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	1 0	aff do not treat the					
	decubitus, only the wound clinic treats the						
		we been trained on					
	-	ntionStaff do not					
	perform decubitus care."						
	An evening obse	ervation was conducted at					
	the group home	on 8/13/12 from 4:45					
	P.M. until 6:45 l	P.M During the entire					
	observation period client #4 complained						
	of pain to his bottom and side. Direct						
	Support Professi	ional #1 and #2 did not					
	acknowledge cli	ent #4's complaints of					
	_	sat in his wheelchair with					
	-	ath him while he watched					
		ved his medications and					
	-	nt #4 was not prompted					
		out of his wheelchair and					
	was not reposition						
	was not repositiv	oned.					
	A morning obse	rvation was conducted at					
	_	on 8/14/12 from 5:40					
		A.M During the entire					
		nt #4 sat in his wheelchair					
	with no cushion	beneath nim.					
	A facility over a	1 day program observation					
	1	d day program observation					
		on 8/14/12 from 11:20					
		P.M. During the entire					
	_	od client #4 sat in his					
	wheelchair with	no cushion.					
		4 4					
	An interview wi						
	conducted on 8/	14/12 at 12:20 P.M					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 51 of 61

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	(X3) DATE SURVEY COMPLETED 08/17/2012	
	PROVIDER OR SUPPLIER		19038 N	ADDRESS, CITY, STATE, ZIP C MISSISSIPPI ST N, IN 46341	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	out of his wheel	e would like to be taken chair at his home and program, client #4 stated				
	conducted on 8/1	nt #4's records was 15/12 at 2:00 P.M #4's record indicated:				
	"Wound: 0.7 cm 0.1 cm100% p	tation dated 3/20/12: n (centimeters) x 0.4 cm x ale pinkcleanse wound nl salineEducation: off n 1 week."				
	"Wound: 0.8 cm healing left ischi three major bone	tation dated 3/27/12: a x 0.6 cm x 0.1 cmNon al (lowest part of the es of the pelvis) wound with normal				
	"Wound: 0.9 cm healing wound	tation dated 4/3/12: a x 0.7 cm x 0.1 cmNon Cleanse wound with ilyBactroban (antibiotic daily."				
	"Wound: 0.8 cm healing wound	tation dated 4/10/12: a x 0.4 cm x 0.1 cmNon Cleanse wound with ilyBactroban twice				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 52 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 08/17/	ETED	
		100010	B. WIN		DDDECC CITY CTATE 7ID CODE	00/17/	2012
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			N, IN 46341		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG		otation dated 4/19/12:		TAG			DATE
		wound clinic, left ischial					
	wound persist.	•					
	_	was debrided, will					
	switch to Santyl						
	ointment)dailyCleanse wound with normal saline dailySantyl daily."						
	Wound clinic no	otation dated 4/24/12:					
	"Wound: 0.7 cm x 0.4 cm x 0.1 cmNon healing woundCleanse wound with						
		ilyBactroban twice					
	daily."						
	Wound clinic no	otation dated 5/1/12:					
		n x 0.3 cm x 0.1 cm90%					
		ng woundCleanse					
	wound with nor	nal saline					
	dailyBactrobar	n twice daily."					
	Wound clinic no	otation dated 5/8/12:					
	"Wound: 0.4 cn	n x 0.3 cm x 0.1					
	cmHealing wo	oundSeven					
	dayAquacel (v	wound dressing)Do not					
	remove or get w	et."					
	Wound clinic no	otation dated 5/15/12:					
	"Wound: 0.4 cn	n x 0.3 cm x 0.1 cmNon					
	_	Cleanse wound with					
	normal salineC	0 ,					
	daysHydrocoll	oid (wound dressing)."					
	Wound clinic no	otation dated 5/22/12:					
	"Wound: 0.6 cn	n x 0.4 cm x 0.1					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 53 of 61

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G313	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	(X3) DATE SURVEY COMPLETED 08/17/2012		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	cmCleanse with normal salineChange every 3 daysHydrocolloidEducation: Off loading."						
	Wound clinic notation dated 5/29/12: "Wound: 1.0 cm x 0.5 cm x 0.1 cm100% pinksuperficialNon healing woundLidocaine 5% topical ointmentSeven day dressingSantylDo not remove or get wetHydrofera Blue (wound dressing)Education: Use cushion in wheelchair while sitting." Wound clinic notation dated 6/5/12: "Poorly healing wound 0.5 cm x 0.5 cm x 0.1 cmPoorly healing woundSeven day dressingSantylDo not remove or get wetHydrofera Blue." Wound clinic notation dated 6/12/12: "Non healing wound 0.9 cm x 0.5 cm x 0.1 cmSuperficial paleCleanse wound with normal saline, change dressing every other dayAquacelChange outer dressing if soiled." Wound clinic notation dated 6/21/12: "Non healing wound 0.8 cm x 0.8 cm x 0.1 cm100% pale pink woundPoorly healing woundCleanse wound with normal saline dailySantylOff						
	0.1 cmSuperficial paleCleanse wound with normal saline, change dressing every other dayAquacelChange outer dressing if soiled." Wound clinic notation dated 6/21/12: "Non healing wound 0.8 cm x 0.8 cm x 0.1 cm100% pale pink woundPoorly healing woundCleanse wound with						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 54 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		15G313	B. WIN	G		08/17/20	012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
4D0.0F	NODEL WATER IND	IANIA INIC. THE			MISSISSIPPI ST		
	ARC OF NORTHWEST INDIANA INC, THE			HEBRO	N, IN 46341		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Wound clinic notation dated 7/12/12: "Poorly healing wound 0.9 cm x 0.7 cm						
	, , ,						
		y healing woundSeven					
	day dressingSantylDo not remove or get wetHydrofera Blue."						
	Wound alinia na	station dated 7/10/12.					
	Wound clinic notation dated 7/19/12: "Non healing wound 0.6 cm x 0.5 cm x						
	_	aling wound100%					
		•					
	paleSantylDo not remove or get wetHydrofera Blue."						
	wetnydroiera	Diue.					
	Wound clinic notation dated 7/26/12:						
		ound 0.5 x 0.5 x					
	_	healing woundSeven					
		loflex pad (wound					
	dressing)Do no	- '					
	diessing)Do in	ot remove.					
	Wound clinic no	otation dated 8/2/12:					
		wound 1 cm x 0.8 cm x					
	0.1 cmPaleN						
		cellerate (antibiotic					
		und bed every other day,					
	· · · · · · · · · · · · · · · · · · ·	ellerate from wound bed					
		e on each dressing."					
	Jast Temppin inoi						
	Wound clinic no	otation dated 8/9/12:					
		ound 0.8 cm x 0.4 cm x					
		healing woundSeven					
	1	antylDo not remove or					
	get wetHydrof	-					
	A confidential in	nterview with DSPs #16					
	and #17 was conducted. DSP #16 stated						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 55 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G313	B. WIN	IG		08/17/	2012
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SULLEIE			19038 N	MISSISSIPPI ST		
	ARC OF NORTHWEST INDIANA INC, THE			HEBRO	N, IN 46341		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		<u> </u>		TAG	BEIGENCT		DATE
		ow they expect [client #4]					
		ey never get him out of his					
		nen asked if client #4 had					
		chedule/alternative					
	_	e, both DSP #16 and #17					
		hen asked if staff					
		ly checks on client #4,					
	-	nd #17 stated "No."					
		hey were trained on how					
		t #4's wound, DSPs #16					
		No." When asked if there					
	was a pain assessment tool used to						
		4's complaints of pain,					
		and #17 stated "No."					
	When asked if n	ursing staff changes					
	client #4's woun	d bandaging, DSPs #16					
	and #17 stated "	No."					
	A review of the	facility's employee					
		ducted on 8/17/12 at 1:00					
		f the employee records					
		e any training for any staff					
		he group home on					
		tocol on client #4's					
		d seating needs, pain					
		how client #4's wound					
	dressing should						
	dressing should	be monitored.					
	An interview wi	th the group home nurse					
		on 8/15/12 at 2:25 P.M					
	The nurse stated	"This sunday was the					
		to the group home and I					
		are things that need to be					
		ent #4]. The nurse					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 56 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		A. BUILDING B. WING	COMPLETED 08/17/2012				
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 19038 MISSISSIPPI ST HEBRON, IN 46341					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX (E/CRO) TAG	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	indicated there was no documentation available for review to indicate a repositioning/alternative seating schedule for client #4. The nurse also indicated there was no documentation available for review to indicate staff conducted body checks on client #4 to check for skin break down. When asked if there was a pain assessment tool used for client #4's complaints of pain, the nurse indicated there was not. When asked if there was any documentation available for review to indicate all staff working with client #4 were trained on his medical needs, she indicated there was not. 9-3-6(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 57 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED	
		15G313	B. WIN			08/17/2012	
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MISSISSIPPI ST		
ARC OF NORTHWEST INDIANA INC, THE					N, IN 46341		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ie	DATE
TAG W0484	483.480(d)(3) DINING AREAS AThe facility must echairs, eating uter to meet the development. Based on observation facility failed for #2, #3, #4 and #5 home to provide knives at the dinitial findings include. An evening obset the group home of P.M. until 6:45 P clients #1, #2, #3 which consisted macaroni and call Client #3 tried to chicken from the the kitchen and golient #3's chicken substitute, peppe knives were avail #3, #4 and #5's until A morning obsert the group home of the group home of the group home of the group home of the string and the group home of t	AND SERVICE equip areas with tables, nsils, and dishes designed opmental needs of each ation and interview, the so of 5 clients (clients #1, 5) living in the group condiments and butter ing table. Evaluation was conducted at the son 8/13/12 from 4:45 P.M At 6:35 P.M., 8, #4 and #5 ate dinner of chicken leg quarters, lifornia blend vegetables. To use his fork to tear the sone. DSP #1 went into got a butter knife and cut en up. No salt/salt ar, butter, ketchup or lable for clients #1, #2,	Wo		The Service Coordinator will re-train the DSP to have condiments and butter knives available to all clients during a meal times. To ensure future compliance, the Service Coordinator will make random visits to monitor the complete dining experience at least twic month for three months and bi-monthly thereafter.	II	DATE 09/16/2012
	chents #1, #2, #3	3, #4 and #5 ate breakfast					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 58 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CO A. BUILDING B. WING	00 	COMPLETED 08/17/2012	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	19038 N	ADDRESS, CITY, STATE, ZIP CODE MISSISSIPPI ST DN, IN 46341		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG	which consisted of oatmeal, scrambled eggs and biscuits. There was no salt/salt substitute, pepper, sugar/sugar substitute, cinnamon or milk on the table available for clients #1, #2, #3, #4 and #5's use. An interview with the Service Coordinator (SC) was conducted on 8/17/12 at 2:00 P.M The SC indicated condiments and knives should be put on the table for the clients to use at all meals. 9-3-8(a)	TAG	DEFICIENCY		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 59 of 61

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G313	B. WING			08/17/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MISSISSIPPI ST		
ARC OF NORTHWEST INDIANA INC, THE					N, IN 46341		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'E	DATE
TAG W0488	Has.480(d)(4) DINING AREAS AThe facility must a in a manner considevelopmental level living in the group at the main course of the group home of the group h	AND SERVICE assure that each client eats istent with his or her wel. ation and interview, the assure 5 of 5 clients up home (clients #1, #2, articipated in preparing for dinner. : arvation was conducted at the service of the ser	Wo		The Service Coordinator will retrain DSP to have clients participate in the dining experience to the extent of the assessed capabilities. To ensufuture compliance, the Service Coordinator will make random visits to monitor participation a least twice a month for three months and bi-monthly thereat	ir ure	09/16/2012
	in preparing the i	main course for dinner.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet Page 60 of 61

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G313		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/17/2012		
	PROVIDER OR SUPPLIE		19038	ADDRESS, CITY, STATE, ZIP MISSISSIPPI ST DN, IN 46341	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	9-3-8(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JG4711

Facility ID: 000832

If continuation sheet

Page 61 of 61